DENTAL PLAN - 2007

Administered by Blue Cross/Blue Shield of Montana
1-800-423-0805 or 444-8315 • www.bluecrossmontana.com

Good News
2007
yearly
maximum
increased
to $1200!

Deductible
$50/Member
$150/Family

	Monthly/Per Paycheck Premiums
Member/Retiree only	$27.80/$13.90
Member/Retiree and spouse	$33.80/$16.90
Member/Retiree and children	$40.80/$20.40
Member/Retiree and family	$45.80/$22.90
Joint Core	$33.80/$16.90

Covered Services	Plan Pays	Limitations/Maximums
Type A: Preventive and Diagnostic	• 100%**	• One full-mouth X-ray or series in any 36-month period. • One set of supplementary bitewing X-rays in any 180-day period. • Two exams and/or cleanings in any benefit year. (Fluoride application covered through age 16.) • No deductible or yearly dollar maximum apply.
Type B: Fillings, Oral Surgery, etc.	• 80%**	• Subject to $50 combined (with type C) deductible • Subject to **$1,200** combined (with type C) yearly maximum
Type C: Dentures, Bridges, etc.	• 50%**	• Subject to $50 combined (with type B) deductible • Subject to **$1,200** combined (with type B) yearly maximum • Dental sealants – limited to covered dependents under age 16 – may be applied to molars once per tooth per lifetime.

**Of allowable charges.

GENERAL INFORMATION

WHO IS ELIGIBLE?

Employees are required to be enrolled in dental coverage unless they waive the entire benefit package. Members also choose which dependents to cover. During the Annual Change period, you may add and/or delete dependents from the dental plan by selecting the appropriate boxes on the Individual Benefit Statement or online as described on page 4.

SERVICE TYPES

Dental plan benefits are paid differently depending on the type of service received.

There is a $50 per member, $150 family deductible for Type B & C services only. The deductible does not apply to Type A preventive services.

Each member and dependent has a maximum yearly benefit of **$1,200** for Type B & C services only.

If you use a Blue Cross Blue Shield participating dentist, you will not be responsible for costs beyond the allowable charges for covered services.

Type A Services

The Dental Plan pays 100 percent of the allowable charges for Type A Services (not subject to deductible):

1. Diagnostic – Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment. Dental X-rays are limited to one full mouth X-ray or series in any 36-month period and not more than one set of supplementary bitewing X-rays in any benefit year.

2. Preventive – Oral examination, including prophylaxis (cleaning) and topical application of fluoride for dependent children under 16 years of age, but *not more than two examinations and/or applications in any benefit year*.

3. Unscheduled minor emergency treatment to relieve pain.

Type B Services

The Dental Plan pays 80 percent of the allowable charges (after deductible) for Type B Services:

1. Passive space maintainers
2. Extractions
3. Fillings
4. Mucogingivoplastic surgery
5. Endodontics
6. Periodontics
7. Oral surgery

Type C Services

The Dental Plan pays 50 percent of the allowable charges (after deductible) for Type C Services:

1. Crowns, bridge abutments (bridge retainers crowns), inlays, onlays, pontics and gold and porcelain fillings. Replacement of crowns is limited to once every five years.

2. Bridges.

3. Repair and rebasing of existing dentures.

4. Initial and replacement dentures, limited to no more than one set of replacement dentures in any 5-year period.

5. Up to $1,500 per person, per lifetime for dental implants while under the plan. This maximum is separate from the yearly maximum.

6. Dental sealants, limited to covered dependents under age 16 applied to molars once per tooth per lifetime. Repair and resealing are not covered.